Medication Self-Carry Form

CONROE INDEPENDENT SCHOOL DISTRICT
Committed to Excellence

Student Information

Student's name

Grade | School year | Date of birth

Teacher's name

Parent's/Guardian's name

Parent's/Guardian's address

Parent's/Guardian's home phone

Parent's/Guardian's work phone

Emergency contact name

Emergency contact relationship

Emergency contact phone number

Physician's Name

Physician's phone number

This student has been instructed and has good understanding of the clinical indications to administer the medication listed on this page.
This student has been instructed and is capable of administering this medication in the event of an allergic reaction/asthmatic event.
_____ Yes _____ No

School Nurse's signature | *Date*

Self-Administration of Asthma or Anaphylaxis Medications

Bronchodiliator *(quick-relief medication)*

Name of medication

Purpose of medication

Dosage of medication

When to use medication

Can be repeated for severe breathing difficulty

_____ times _____ minutes apart.
Call 911 or EMS if minimal or no improvement.

Epinephrine Auto-Injector

Name of medication

Purpose of medication

Dosage of medication

When to use medication

Additional instructions

☐ I have instructed *(student's name)* _____
in the proper way to use his/her medications. It is my professional opinion that *(student's name)* _____ **should be allowed** to carry and self-administer the following medications while on school property or at school-related events.

☐ It is my professional opinion that *(student's name)* _____ **should *not* be allowed** to carry and self-administer the following medications while on school property or at school-related events.

Physician's signature | *Date*

I agree with the recommendation of my child's physician as noted and have informed my child that he/she may carry his/her asthma or anaphylaxis medications while on school property or at school-related events.

Parent's signature | *Date*